DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/09/2011	
NAME OF F	PROVIDER OR SUPPLIER			231 N J	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST		
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER		OAKLA	ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
K0000							
K0000	and State Licenconducted by the Department of accordance with Survey Date: In Facility Number Provider Number AIM Number: Surveyor: Lex Code Specialist At this Life Safe Good Samarita Rehabilitation on the compliant Requirements of Medicare/Medi Subpart 483.70 from Fire and the National Fire Association (NIC Code (LSC), Chellealth Care Octored (LSC), Chellealth Care (LSC), Chellealth C	h 42 CFR 483.70(a). 1/09/11 r: 000327 er: 155561 100273920 Brashear, Life Safety ety Code survey, n Home & Center was found nce with for Participation in caid, 42 CFR D(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing ecupancies and 410 facility with two	K	0000			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE S COMPL 11/09/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		DDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER			ACKSON ST ID CITY, IN47660		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	·		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	construction ar	be of Type V (000)					
		ne facility has a fire					
	alarm system w						
	detection on both levels including						
	the corridors and spaces open to						
	the corridors. The facility has a						
	capacity of 110 and had a census						
of 81 at the time of this survey.							
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/15/11.						
	The facility was	found not in					
	compliance wit	h the					
	aforementioned	d regulatory					
	I	s evidenced by the					
	following:						
K0029		d construction (with ¾ hour					
SS=E		r an approved automatic fire em in accordance with 8.4.1					
	and/or 19.3.5.4 pro	otects hazardous areas.					
	When the approve	ed automatic fire em option is used, the areas					
		n other spaces by smoke					
		and doors. Doors are					
		on-rated or field-applied hat do not exceed 48 inches					
		f the door are permitted.					
	Based on obser	vation and	K0	029	K 029 What corrective actio		11/23/2011
	interview, the f	acility failed to			will be accomplished for the residents found to have bee		
		hazardous area			affected by the deficient		
	room doors, su	ich as a room over			practice; No residents were		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155561 11/09/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 231 N JACKSON ST GOOD SAMARITAN HOME & REHABILITATIVE CENTER OAKLAND CITY, IN47660 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE affected. Items from room 105 100 square feet containing a large removed. How other residents amount of combustible material having the potential to be such as cardboard boxes, was affected by the same deficient equipped with a self closing device practice will be identified and what corrective action(s) will on the door. This deficient be taken: All residents had the practice could affect 11 residents, potential to be affected. Items in as well as staff and visitors in the room 105 removed What 100 hall Station 3 area. measures will be put into place or what systematic changes will be made to ensure that the Findings include: deficient practice does not recur. Resident rooms will not be Based on observation on utilized for storage. Maintenance 11/09/11 at 11:15 a.m. during a Director or designee will perform weekly rounds to monitor for tour of the facility with compliance. How the corrective Maintenance Supervisor, room 105 action(s) will be monitored to was over one hundred square feet ensure the deficient practice in size and full of at least fifteen will not recur i.e. What quality large cardboard boxes. The door assurance program will be put into place. Maintenance Director to this room was not provided will provide Quality Improvement with a self closing device. This Committee overseen by was acknowledged by the Executive Director. Date of Completion 11-23-2011 Maintenance Supervisor at the time of observation. 3.1-19(b)Exit access is arranged so that exits are K0038 readily accessible at all times in accordance SS=E with section 7.1. 19.2.1 K 038 K0038 11/23/2011 Based on observation and What corrective action(s) will interview, the facility failed to be accomplished for those ensure 1 of 8 exits was residents found to have been maintained to provide safe access affected by the deficient to the public way in accordance practice;

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Event ID:

7QZV21

Facility ID:

000327

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561			LDING	NSTRUCTION 01	(X3) DATE SI COMPLE 11/09/20	TED	
		& REHABILITATIVE CENTER FATEMENT OF DEFICIENCIES	<u>, </u>	231 N JA	DDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
	7.1.6.3 require shall be nominal deficient praction to 20 residents and visitors in the 2 during an evaluation of the facion Maintenance Successive Cottage Unit # discharged onto platform which concrete sidewithe public way, platform was concrete in several was loose gravalso, making it in the event of This was acknown Maintenance Successive Cottage Unit # discharged onto platform which concrete sidewith public way, platform was concrete in several laso, making it in the event of This was acknown Maintenance Successive Cottage Unit # discharged onto platform was concrete sidewith public way.	ce could affect up , as well as staff the Cottage Unit # acuation. e: vation on 1:50 a.m. during a lity with the upervisor, the 2 south exit o a concrete was connected to a alk which lead to The concrete racking and was ral places. There vel on the platform difficult to traverse an evacuation. wledged by the upervisor at the ation.			No residents were found to heen affected. Concrete land outside of Cottage 2 emerger exit door was resurfaced. How other residents having the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken; All residents had the potential be affected. Concrete landing outside of Cottage 2 emerger exit door resurfaced. What measures will be put place or what systematic changes will be made to ensure that the deficient practice does not recur. Maintenance Director will perweekly rounds to monitor for safety on grounds. How the corrective action(s will be monitored to ensure deficient practice will not rei.e, What quality assurance program will be put into pla Maintenance Director will brir results of rounds to Quality Improvements Committee, overseen by Executive Direct grounds are not up to Life Sa expectations a plan of action be implemented. Date of Completion 11-23-26	by will al to general into	
K0047 SS=E	accordance with s illumination also se	al signs are displayed in ection 7.10 with continuous erved by the emergency 19.2.10.1					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	onstruction 01	(X3) DATE COMPL	
		155561	B. WIN			11/09/2	011
			D. WII	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t.		231 N J	ACKSON ST		
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER			ND CITY, IN47660		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	Based on obse	rvation and	K(0047	K 047	.:11	11/23/2011
	interview, the facility failed to				What corrective action(s) was be accomplished for those	/111	
	ensure a contir	nuously illuminated			residents found to have be	en	
	exit sign, wher	e the exit or way to			affected by the deficient	···	
	reach the exit v	was not apparent,			practice;		
	was provided o	• • •			No resident was affected. Ex	cit .	
		.2.10.1 refers to			sign relocated appropriately		
					above new emergency exit on How other resident's havin		
	7.10. LSC 7.10.1.4 requires access to exits shall be marked by				the potential to be affected	_	
	approved, readily visible signs in				the same deficient practice	-	
	all cases where the exit or way to				be identified and what		
	-				corrective action(s) will be		
	reach the exit is not apparent to				taken;		
	the occupants.				All resident's had the potenti		
	l ·	affect 16 residents,			be affected. Exit sign relocat appropriate emergency exit		
	as well as staff	and visitors in			appropriate emergency exit	door.	
	Cottage Unit #	1.			What measures will be put	into	
					place or what systematic		
	Findings includ	le:			changes will be made to		
					ensure that the deficient		
	Based on obse	rvation on			practice does not recur. Maintenance Director will pe	rform	
	11/09/11 at 10	0:45 a.m. during a			weekly rounds to monitor for		
	tour of the faci	-			appropriately placed signage		
		upervisor, there was			proper functioning.		
		ver the east exit			Upur the commenture and and		
		age Unit # 1. This			How the corrective action(s be monitored to ensure the	•	
	was acknowled	-			deficient practice will not i		
		upervisor at the			i.e, What quality assurance		
	time of observa	·			program will be put into pla	ace.	
	time or observa	ation.			Maintenance Director will re		
	2.1.10(1)				findings to Quality Improver Committee overseen by	nent	
	3.1-19(b)				Executive Director. If Life Sa	afety	
					requirements are not met an		
					action plan will be implemen	ted.	
					Date of Completion 11-23-2	011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JETIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	
		155561	B. WIN	G		11/09/2	011
NAME OF DD	OVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF PRO	OVIDER OR SUPPLIER			231 N J	JACKSON ST		
GOOD SA	MARITAN HOME 8	& REHABILITATIVE CENTER		OAKLA	ND CITY, IN47660		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
1200.0	•	plan for the protection of all error					
OO .	of an emergency.	19.7.1.1					
i	Based on record review and interview, the facility failed to		K(0048	K 048		
					What corrective action(s) was be accomplished for those		
	•	lete written fire			residents found to have be		
	safety plan for t	the protection of			affected by the deficient		
	81 of 81 reside	nts in the event of			practice;		
	an emergency a	iddressing all items			No residents were affected.		
	required by NFF	PA 101, 2000			Disaster Policy updated to address the use of ABC type	e fire	
	edition, Section	19.7.2.2. LSC			extinguishers located throughout		
	19.7.2.2 require	es a written health			the building. Disaster policy		
	care occupancy fire safety plan	fire safety plan			updated to reflect K class fire		
	that shall provid	de for the			extinguishers located in kitch relationship with the use of	ien in	
	following:				kitchen overhead extinguishi	ing	
	(1) Use of alarm	ıs			system.		
	(2) Transmissio	n of alarm to the			How other residents having		
	fire department				the potential to be affected the same deficient practice	-	
	(3) Response to	alarms			be identified and what		
	(4) Isolation of	fire			corrective action(s) will be		
	(5) Evacuation c	of immediate area			taken;	-14-	
	(6) Evacuation o	of smoke			All residents had the potential be affected. Disaster Policy	ai to	
	compartment				updated to address the use	of	
	(7) Preparation	of floors and			ABC type fire extinguishers		
	building for eva				located throughout the buildi	•	
	(8) Extinguishm	ent of fire			Disaster policy updated to re K class fire extinguishers loo		
-	This deficient p	ractice could affect			in kitchen in relationship with		
	=	the event of an			use of kitchen overhead		
	emergency.				extinguishing system.		
	<i>- '</i>				What measures will be put place or what systematic	into	
	Findings include	e:			changes will be made to		
	Tillanigs melade.			ensure that the deficient			
	Based on a revie	ew of the facility's			practice does not recur.		
	U.				Maintenance Director will mo	onitor	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/09/2011
	ROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	STREET A	ACKSON ST ND CITY, IN47660	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	"Disaster Plan" 9:50 a.m. with Supervisor presiplan did not ad the ABC type fillocated through the K class fire located in the k relationship witk kitchen overhea system. Based the time of reco Maintenance Su acknowledged safety plan did of the ABC type or the kitchen se activate the over extinguishing se	citchen in th the use of the ad extinguishing on an interview at ord review, the upervisor the written fire not include the use e fire extinguishers staff training to		and update disaster policy a changes to expectations on How the corrective action will be monitored to ensur deficient practice will not it.e, What quality assurance program will be put into ple Maintenance Director will a Quality Improvement Commof Life Safety regulation chat Quality Improvement Commovill assure Disaster Policy is updated as needed. Date of Completion 11-27-	ccur. (s) re the recur e lace. lert nittee anges. nittee
K0062 SS=E	continuously main condition and are	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13,			
	1. Based on ob interview, the f ensure 1 of 1 s		K0062	K 062 What corrective action(s) to be accomplished for those residents found to have be affected by the deficient	e

000327

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155561	A. BUII	LDING	01	11/09/2011
		199901	B. WIN	_		11/09/2011
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
					ACKSON ST	
GOOD S		& REHABILITATIVE CENTER		OAKLAI	ND CITY, IN47660	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	t # 2 was free of			<pre>practice; No resident's were affected.</pre>	
	obstructions to	the spray pattern.			Sprinkler heads in Memory (Care
	NFPA 25, 2-2.	1.2 requires			Facilitator's office removed a	
	unacceptable c	bstructions to			relocated to an area that me	
	spray patterns	shall be corrected.			Fire Safety codes. Sprinkler	
	1	FPA 13, Installation			Heads in employee break ro	
		stems, 4-5.51.1			were exchanged with sprinkly	
	requires sprink				heads that meet Fire Safety How other resident's havin	
	located as to m				the potential to be affected	<u> </u>
					the same deficient practice	=
		discharge. NFPA			be identified and what	
	13 at 5-6.3.3 requires a minimum				corrective action(s) will be	
	of 4 inches bet	ween the sprinkler			taken;	
	and the wall.	This deficient			All resident's had the potenti	al to
	practice could	affect 20 residents,			be affected.	S
	l -	and visitors in			Sprinkler heads in Memory (Facilitator's office removed a	
	Cottage Unit #				relocated to an area that me	
					Fire Safety codes. Sprinkler	
	 Findings institut	Ja.			Heads in employee break ro	om
	Findings includ	ie.			were exchanged with sprink	
]				heads that meet Fire Safety	
	Based on obse				What measures will be put	into
		2:05 p.m. during a			place or what systematic changes will be made to	
	tour of the faci	lity with the			ensure that the deficient	
	Maintenance Si	upervisor, the			practice does not recur.	
	pendant sprink	der head in the			Maintenance Director will pe	rform
	l ·	cilitator Office in			weekly inspections to monitor	
		2 was within one			compliance for appropriate	
	_	l (ceiling bulkhead)			placements and condition of	
		strict the spray			sprinkler heads. How the corrective action(s	s)will
					be monitored to ensure the	•
	I =	sprinkler head in			deficient practice will not i	
		prinkler head was			i.e, What quality assurance	
		was acknowledged			program will be put into pla	
	by the Maintenance Supervisor at				Maintenance Director will pro	
	the time of obs	servation.			Quality Improvement Comm	ittee,
FORM CMS-2	L 2567(02-99) Previous Versi	ons Obsolete Event ID: 7	 'QZV21	Facility I	ID: 000327 If continuation s	heet Page 8 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561				LDING	nstruction 01	CON	TE SURVEY MPLETED 19/2011
NAME OF P	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP C	CODE	
GOOD S	AMARITAN HOME	& REHABILITATIVE CENTER			ACKSON ST ND CITY, IN47660		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
	1				CROSS-REFERENCED TO THE A		
PREFIX TAG	3.1–19(b) 2. Based on old interview, the fensure 1 of 2 state Employee Editor of paint. NFPA the Inspection, Maintenance of Protection Systems 2–2.1.1 requires free of paint. A deficient praction of the 81 residustaff and visitor Physical Therappart of the same compartment. Findings include Based on obsems 11/09/11 at 11 tour of the facion Maintenance State Sprinkler head the Employee Editor of the administration of the same compartment.	oservation and facility failed to sprinkler heads in Breakroom was free 101 Section 9.7.5 25, Standard for Testing, and f Water-Based Fire tems. NFPA 25 es sprinklers to be Any sprinkler shall at is painted. This ice could affect any ents, as well as the syroom which was ne smoke de: rvation on 2:20 p.m. during a fility with the upervisor, the in the front part of		PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE APPROPRIATE Ve Director, and if not in a plan will be	COMPLETION DATE
	on the fusible link. This was						
	acknowledged	by the Maintenance					
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	7QZV21	Facility I	D: 000327 If con	tinuation sheet	Page 9 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155561		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE S COMPLI 11/09/20	ETED	
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER		231 N J	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Supervisor at the observation.	ne time of					
K0066 SS=E		ns are adopted and include ollowing provisions:					
	(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.						
	responsible is prol direct supervision. (3) Ashtrays of no safe design are pr	ncombustible material and ovided in all areas where					
	devices into which are readily available smoking is permitted. Based on observinterview, the frensure cigarette were properly of 2 smoking area.	rs with self-closing cover a ashtrays can be emptied ble to all areas where sed. 19.7.4 evation and facility failed to se butts and ashes disposed of for 2 of as. This deficient affect any residents smoke.	K0	0066	What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. Appropriate containers for cigarette butts/ashes have been placed in smoking areas. How other residents having the potential to be affected the same deficient practice	een J by	11/27/2011

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	COMPL	
		155561	A. BUII B. WIN	LDING G		11/09/2	011
		& REHABILITATIVE CENTER		231 N J	DDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
V0144	1:15 p.m. during facility with the Supervisor, the area was using concrete planted of cigarette butts of cigarette butts containers with were not provided smoking area. The resident smoking area are sident smoking courtyard had to planters for the cigarette butts, metal containers overs. The planters for the cigarette butts, metal containers with contained cigarette butts each, and contained cigarette butts each, and containers with contained cigarette butts. The contained cigarette butts each, and contained cigarette butts each, and contained cigarette butts each, and contained cigarette butts. The contained cigarette butts each, and contained cigarette butts. The planter butts each, and contained cigarette butts each, and contained cigarette butts. The planter butts each, and contained cigarette butts each, and contained cigarette butts. The planter butts each, and contained cigarette butts each, and contained cigarette butts.	reen 10:30 a.m. and any a tour of the Maintenance employee smoking two large open ers for the disposal ets. The planters with hundreds of each. Metal self closing lids ded in the employee Furthermore, the any area within the ewo large concrete edisposal of as well as two ers with self closing enters were both eds of cigarette lithe metal self closing covers rette butts and his was by the Maintenance me time of each			be identified and what corrective action(s) will be taken; All residents had the potential be affected. Appropriate containers for cigarette butts/ashes have be placed in smoking areas. What measures will be put place or what systematic changes will be made to ensure that the deficient practice does not recur. Maintenance Director will pe weekly rounds to monitor for proper containers for cigaret butt/ashes disposal. How the corrective action(s will be monitored to ensure deficient practice will not rei.e, What quality assurance program will be put into pla Maintenance Director will repfindings to Quality Improvem Committee, overseen by Executive Director, if not compliant an action plan will developed. Date of Completion 11-27-2	rform tte cur ce. cort ent	
K0144 SS=F		spected weekly and ad for 30 minutes per ace with NFPA 99.					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561		LDING	01	· ′	ESURVEY LETED 2011
	PROVIDER OR SUPPLIER	& REHABILITATIVE CENTER	<u>'</u>	231 N J	ADDRESS, CITY, STATE, ZIP CODE ACKSON ST ND CITY, IN47660	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
FORM CMS-	ensure 1 of 1 egenerators was remote manual requires emergy providing power lighting system tested and mai accordance with Standard for Ensurement Standby Power 110, 1999 edit requires Level have a remote of a type similar station located premises where is located outs NFPA 37, Standard Installation and Combustion Ensurement Installation Installation and Combustion Ensurement Installation Ins	facility failed to emergency is equipped with a listop. LSC 7.9.2.3 gency generators er to emergency insight shall be installed, intained in the NFPA 110, intergency and systems. NFPA sion, 3–5.5.6 Ill installations shall manual stop station ar to a break-glass elsewhere on the ethe prime mover ide the building. dard for the diuse of Stationary ingines and Gas is Edition, at 8–2.2(c) es of 100 more have hutting down the engine and from a in. This deficient affect all occupants ide:	QZV21	D144	K 144 What corrective action(s) be accomplished for tho residents found to have affected by the deficient practice; No residents were affecte Remote kill switch installe appropriate area per Life state the same deficient practice be identified and what corrective action(s) will staken; All residents had the pote be affected. Remote kill swinstalled in appropriate and Life Safety. What measures will be place or what systematic changes will be made to ensure that the deficient practice does not recur. Maintenance Director will monitor/audit kill switch furby testing quarterly. How the corrective action will be monitored to ensure that the deficient practice will monitor/audit kill switch furby testing quarterly. How the corrective action will be monitored to ensure that quality assurant program will be put into Maintenance Director will Quality Improvement Corroverseen by Executive Director will quality Improvement Corroverseen by Executive Director will proven action plant developed.	d. d in Safety. ing ted by ce will be ntial to witch tea per out into trecur ce place. provide imittee, rector, will be	11/18/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/09/2011
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN47660		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
	1:15 p.m. during facility with the Supervisor, a redevice for the Gound. Based of time of exit into on 11/09/11, indicated the goinstalled after a indicated there	veen 10:30 a.m. and ng a tour of the e Maintenance emote shut off generator was not on interview at the erview at 1:25 p.m. the Administrator		Date of Completion 11	-18-2011